Recertification in the medical specialties: a way forward

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ABSTRACT – Revalidation will have two core components: relicensure and specialist recertification. All doctors wishing to practise in the UK will require a licence issued by the General Medical Council and those on the specialist register will also be required to demonstrate that they meet the standards that apply to their medical specialty. Eight methods of evaluating performance are considered in this paper – all provide opportunities to reflect on clinical practice and to raise standards. A blueprint might be used to ensure that relicensure and specialist recertification sample different domains of clinical practice during the five-year cycle, but time and money will be required to develop standards that are valid, reliable and assessable, as well as to pilot and implement the specialty-specific tools required for assessing such standards. The Royal College of Physicians and the medical specialties must engage with this process so that specialist recertification is acceptable and achievable.

KEY WORDS: blueprint, evaluating performance, relicensure, revalidation, specialist recertification

Introduction

The February 2007 white paper entitled *Trust, assurance and safety – the regulation of health professionals in the 21st century*[1] endorses the recommendations of the Chief Medical Officer[2] and sets out proposals:

> *to ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.*

Revalidation will have two core components: relicensure and specialist recertification and the emphasis will be 'a positive affirmation of the doctor's entitlement to practise, not simply the apparent absence of concerns'.

Relicensure

All doctors wishing to practise in the UK will require a licence to practise issued by the General Medical Council (GMC). Relicensure will be required every five years and will be dependent on satisfactory annual appraisals as well as a multi-source feedback exercise. The GMC will have responsibility for assuring the quality of a more robust annual appraisal process, which will assess whether the doctor's performance has met agreed generic standards (set by the GMC). The formative component of appraisal should help doctors to consider any changes that might need to be made. Appraisers will have to be trained to a high standard if this process (a mix of summative and formative assessment) is to succeed. Professional attitudes and behaviour often underlie problems in clinical practice and doctors will also be expected to participate in an independent multi-source (360-degree) feedback exercise in the workplace every five years, probably using a standardised online system. The Royal College of Physicians (RCP) has already piloted tools to support this process. Finally any issues concerning the doctor's conduct or practice will have to have been resolved to the satisfaction of the medical director (or equivalent) before relicensure is confirmed.

Specialist recertification

In addition all doctors on the specialist register will be required to 'demonstrate that they continue to meet the particular standards that apply to their medical specialty' at intervals of no longer than five years. Renewal will be contingent upon the submission of a positive statement of assurance by the relevant royal college to the GMC.

The RCP in collaboration with the specialist societies has begun to consider how standards might be set in each specialty and how practice in accordance with these standards might be evaluated. Just as a blueprint can help those setting examinations to ensure that there is a wide sampling of the knowledge and skills specified in a curriculum, a blueprint might also be used to ensure that relicensure and specialist recertification sample different domains of clinical practice during the five-year cycle. The proposals for evaluating performance discussed in this paper, all of which should provide opportunities for physicians to reflect on their clinical practice and raise standards of care, were informed by the submissions of a British Association of Dermatology/RCP Working Party.

Possible methods of evaluating performance

Complex case presentations

Most physicians already discuss challenging clinical cases with colleagues at multidisciplinary team, pathology or radiology meetings as well as at more formal meetings (local or national). The consultant might be expected to provide documentation that shows that they have discussed the diagnosis and management of an agreed number of cases in the last year. Most consultants attend such meetings regularly and would see this merely as an exercise in documentation of a practice they already undertake. A few consultants would be forced to interact in a greater way with their peers.

Logbook of challenging cases and/or logbook of procedures

Physicians might maintain a record of challenging cases with details of management and how practice changed. Physicians might also be expected to record procedures such as endoscopy, biopsies or cardiac interventions in a logbook, perhaps concentrating on one important aspect of practice. In dermatology, for example, this might be the management of skin cancer. Such logbooks are already used by surgeons in training. The logbook could include:

- procedure/case history
- management, complications and outcome
- reflection on outcome, choice of procedure or how practice might change, particularly if the physician had to deal with complications. Annual appraisal should explore the reflective aspect
- morbidity data.

Direct observation of consultation skills and/or procedural skills

Trainees are assessed using mini-clinical evaluation exercises (CEXs) and direct observation of procedural skills (DOPS). The process could be extended to consultants, but in this case the observation should be formative and could be of benefit to both the observer and the consultant being observed. A minimum of one hour would be required for observation, with additional time for feedback and discussion. Such observations would have to be planned but could be carried out once each year. The consultant would select an observer, who might be a colleague from within the department or from another hospital. Ideally different observers would be selected each year.

Mini-CEX. All physicians should be able to demonstrate competence in outpatient consultations. Competence might be assessed through:

- communication skills including ability to explain the risks and benefits of treatment options, being honest about what we do or do not know, and exploring people's understanding, reactions and opinions
- diagnostic and investigative skills, and management skills
- arrangements for discharge/review
- teamworking, teaching and training.

Direct observation of procedural skills. Consultants should be able to demonstrate technical competence. Competence might be assessed through:

- communication skills including ability to explain the risks and benefits of the procedure clearly and carefully
- choice of procedure, and technical competence
- outcome, including complications
- teamworking, teaching and training.

A form with two sections would be completed at the end of the observation:

- A – feedback for the consultant being observed
- B – notes for the observer on what had been learnt or how their own practice might change as a result of observing a colleague.

Patient feedback

Patients should be involved in judging some aspects of how a doctor performs.[3] A questionnaire might assess whether the doctor had:

- helped a patient to understand and cope with their condition
- given clear, understandable information about diagnosis and treatment
- listened and allowed patients to 'tell their story'
- provided opportunities for patients to ask questions
- involved patients in decisions about care and/or supported self-care.

Patients might be asked to report what occurred with specific questions such as:

- Was the diagnosis provided and explained clearly?
- Were the risks and benefits of treatments explained clearly?
- Do you have a plan to manage your condition?
- Can you cope better with your condition since you saw the doctor?

Ideally, questionnaires would enable patients to assess some aspects of technical competence, as well as the communication skills of a doctor, and to quantify quality in the consultation. More work is needed to develop questionnaires that will produce specific and valid data.

Audit of outpatient clinic letters

All consultants write letters to referring physicians and copies to patients are recommended. The content of letters might be compared against a standard template. Criteria might include:

- diagnosis, or differential diagnosis if no firm diagnosis reached at this stage

- investigations
- treatment: drugs including frequency of dosing and doses; procedures etc
- outcome: success/failure of previous treatment, or referral to other consultants
- follow-up: yes/no – if 'yes', when and with whom?
- a copy being sent to the patient – if not, why not?

Patients might also be asked to comment on the content of letters.

Clinical indicators of practice

An audit of 'clinical indicators of practice' might be used to look at clinical practice. Many specialist societies have agreed guidelines for the management of common diseases. Specialists might set standards and audit the management of one common disease each year on a national basis, perhaps in collaboration with the RCP Clinical Effectiveness and Evaluation Unit, following the 2003 example of the British Thoracic Society. However data may reflect the practice of teams, not individuals; databases that record diagnoses and treatments (particularly in outpatients) are still not widely available and resources would be required to support data collection and analysis.

Knowledge-based assessment

Consultants should be able to demonstrate their ability to access information, that they are maintaining their knowledge and that they can apply that knowledge. The RCP, in collaboration with the specialist societies, is developing banks of questions that are mapped to specialist registrar curricula. Questions should be clinically relevant and test application of knowledge. It would be feasible to assess consultants using these tests of knowledge but a formative, 'open-book' assessment would be more acceptable and feasible than a separate summative 'closed-book' assessment designed specifically for consultants, many of whom have subspecialised. Although superficially attractive, many important aspects of a consultant's role would not be assessed with tests of knowledge.

Conclusions

Doctors should be able to demonstrate competence, but the formative component (the opportunity for reflection and discussion) in relicensure and specialist recertification should be maximised to promote good practice and support doctors, most of whom are already working to high standards.

The government anticipates that 'standards will be tested against the needs of patients and healthcare providers and based on wide consultation with all relevant stakeholders'. The government has also recognised that clinical audit needs to be revitalised so that accurate and meaningful clinical data are collected to assess the performance of individuals. Time (including dedicated time in job plans) and money is required to develop standards that are valid, reliable and assessable as well as to pilot and implement the specialty-specific tools required for assessing such standards. The RCP and the specialist societies should continue to engage with this process so that specialist recertification is acceptable and achievable. Far better that we should do this than that someone should impose a system upon us. The outcome affects us all.

References

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